

# Pure Resolutions LLC

An Independent Review Organization

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Date of Notice: 01/08/2015

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## Review Outcome:

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

## Description of the service or services in dispute:

MRI spinal canal lumbar w/o contrast

**Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:**

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

## Patient Clinical History (Summary)

The patient is a female who reported an injury to her low back on xx/xx/xx when she was involved in a motor vehicle accident. A clinical note dated 12/28/13 indicated the patient complaining of ongoing low back and left leg pain. The patient underwent epidural steroid injection in 10/13 which provided 60% improvement in low back pain. An operative note dated 02/27/13 indicated the patient underwent left L4 transforaminal epidural steroid injection. Operative note dated 02/04/14 indicated the patient undergoing L4-5 epidural steroid injection. An operative note dated 08/05/14 indicated the patient undergoing L4-5 and L5-S1 epidural steroid injection on the left. A clinical note dated 10/16/14 indicated the patient continuing with low back complaints. The patient reported no strength deficits, numbness and tingling, numbness, or tingling. Upon exam the patient demonstrated 4+-5-/5 strength at the lower extremities. Reflexes were absent at bilateral Achilles. A clinical note dated 11/06/14 indicated the patient rating low back pain 5-7/10. Numbness was identified numbness and tingling were identified in the left lower extremity. A clinical note dated 11/25/14 indicated the patient recommended for MRI of the lumbar spine.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.**

The patient complained of ongoing low back pain despite a number of previous epidural steroid injections. The patient recently underwent MRI as recently as 07/14. A repeat MRI of the lumbar spine is indicated for patients who have demonstrated significant changes in symptomology or development of new pathology as determined by clinical evaluation. No information was submitted regarding development of new symptomology or significant changes in pathology. Given this, the request is not indicated as medically necessary. As such, the opinion of this reviewer that the request for MRI of the spinal column spinal canal in the lumbar spine without contrast is non-certify is not recommended as medically necessary.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☒ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☒ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
  
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)